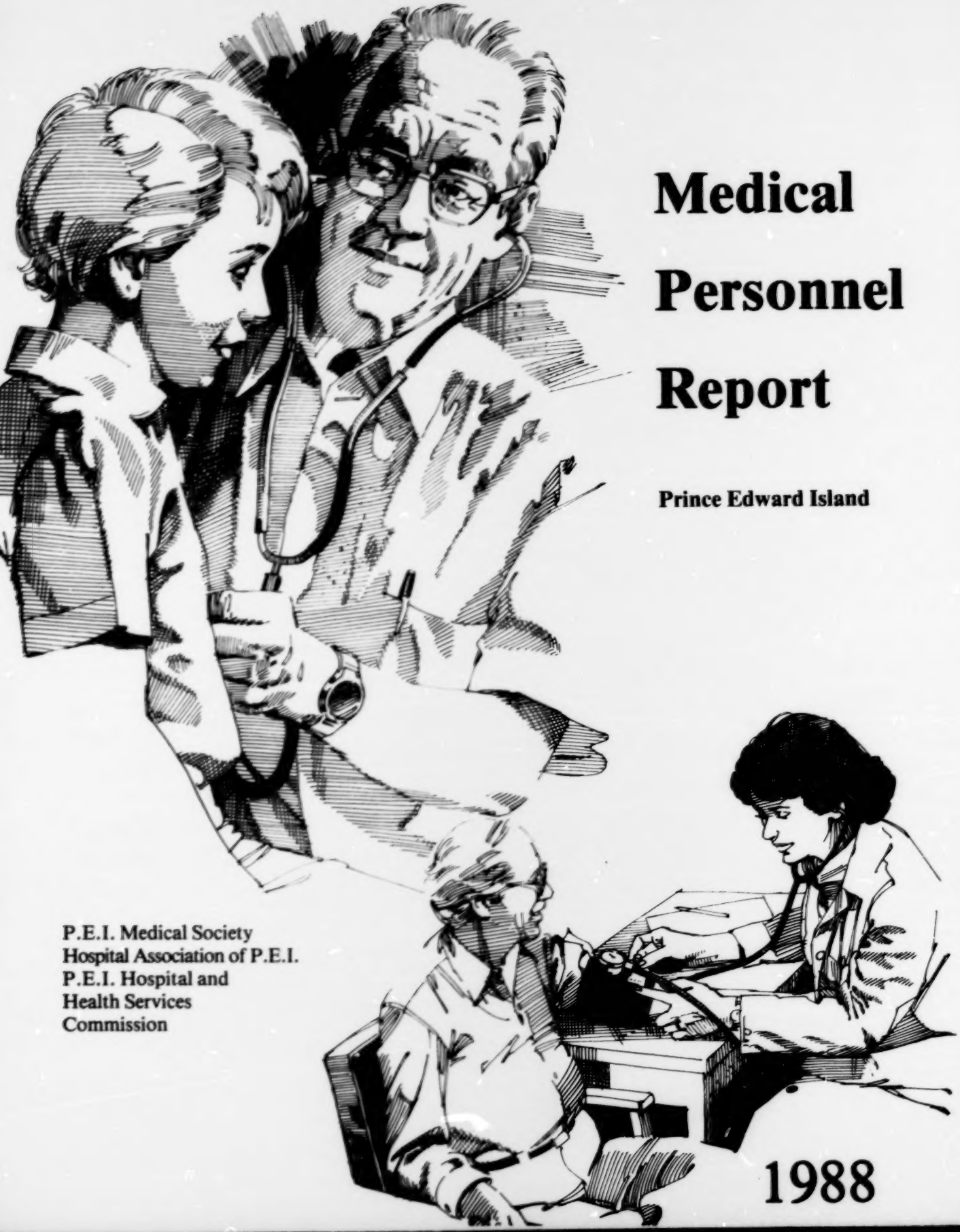

Medical Personnel Report

Prince Edward Island

P.E.I. Medical Society
Hospital Association of P.E.I.
P.E.I. Hospital and
Health Services
Commission

1988

TO ALL READERS:

The Medical Personnel Advisory Committee is pleased to present its report to the three participating parties - the Prince Edward Island Hospital and Health Services Commission, the Hospital Association of Prince Edward Island and the Prince Edward Island Medical Society.

The Report represents the views of the Committee Members. Participation by the above organizations is a sign of cooperation. It does not mean these organizations have sanctioned all elements of the Report.

PRINCE EDWARD ISLAND

MEDICAL PERSONNEL PLAN

June, 1988

90-04284/1

REPORT OF THE PRINCE EDWARD ISLAND MEDICAL PERSONNEL ADVISORY COMMITTEE

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EXECUTIVE SUMMARY

The Government recognized a need to establish a strategy for the development of health care on Prince Edward Island. The Medical Society understood this need and offered to participate in a process which would look at physician planning issues as one of a number of issues that must be addressed in an overall planning process.

A Medical Personnel Advisory Committee was established with representatives from the Medical Society, the Hospital Association and the Hospital and Health Services Commission.

The Committee requested submissions from hospitals, physicians, and the community at large. It reviewed current documentation on physician manpower planning and studied the many complex issues impacting on physician supply.

As might be expected, the nature of this lengthy review process shed light on many matters of health care. The issue of physician supply was broadened to include issues that impact upon or influence that supply. Issues such as the impact of the aging population and technology were explored to understand how physician supply would be influenced by the external environment. The Committee concurred with many presentors that the role of public education and awareness toward the use of physician services must have an increasing emphasis in the future.

The Committee examined the delivery of services from a number of perspectives. The use of out-of-province services and facilities, the growth in out-patient clinics and the provision of specialty clinics by out-of-province physicians require the development of comprehensive policies to ensure the efficient and effective use of these delivery alternatives.

The use of other health professionals to complement or replace the role of the physician was also considered. The concept of the nurse practitioner, midwives, public health nurses, and home care workers was examined. Although a number of these professionals were not considered appropriate for Prince Edward Island at this period of time, there are others that provide very worthwhile services, but need to work more closely with the medical profession in the development and ongoing monitoring of health programs.

A recurring theme in many of the discussions was the need for a clarified role for the family physician. The Committee found that the family physician's role must be not only broadened to include the provision of primary services now being provided by specialists, but they must also have a heightened responsibility for the continuum of care provided by health professionals, this being particularly relevant for the aging patient.

In the evolution of physician requirements, the Committee assessed the need for physicians based on the current complement, the influence of attrition and the evidence of identified need.

The Committee worked with the premise of the Island having five primary care hospitals providing similar services and two hospitals providing secondary and tertiary care. The Committee felt strongly that physician requirements to accommodate roles beyond those currently being met should not be considered until the development of a hospital delivery plan is completed.

The Committee concluded that the greatest area of need is in the specialties, which includes problems of distribution and priorization. With respect to family physicians, there are, in general, adequate numbers but as well distribution is a problem.

The recruitment of specifically skilled physicians poses a major challenge. The Committee believed innovative approaches to recruitment are required if the Province is to secure adequate levels in a broad range of specialty areas.

The Committee concluded that there is general agreement for a managed approach to the provision of physician services. The Committee recommended that a permanent management structure be established to accommodate an ongoing review process and to work on behalf of the total health community in directing and managing the flow of physicians into the Province.

1. INTRODUCTION

1.1 Rationale for Committee

For some time the Hospital & Health Services Commission has recognized a need to develop and manage a strategy for the health care system.

The Commission has historically been responsible for the administration of hospital and medical insurance plans. Government has been somewhat more involved with the hospitals but its involvement with physicians has been primarily in the establishment and interpretation of the Tariff of Fees. In more recent years it has become obvious that greater participation is required among all partners for the appropriate planning and implementation of services.

The Commission's document "New Directions for Management of the Health Care System" which articulates the government sanctioned mandate of the Commission, clearly identifies that "the Commission must, through a partnership with health care providers, facilitate the development of a strategy (strategic plan)."[1]

At the 1987 Financial Post Conference - Health Care in Canada: Can We Afford Unlimited Access?, Ambrose M. Hearn, then Deputy Minister of Health for Newfoundland, stated "it would be a bold, enlightened step for governments to invite the organizations I mentioned above (governments, medical profession, hospitals, nursing profession and unions) to participate in a new partnership - a partnership that is not a political move, that is not a public relations gimmick, that is not a sop, but a genuine and serious effort to resolve our problems. Similarly, it would be an enlightened step by the medical profession, the hospital association and unions to recognize that there is not an unlimited pot of money to provide services and to propose such a partnership. There is a need to depoliticize the health care system - depoliticize in the big "P" sense and in the small "p" sense - to move away from confrontation and to move towards co-operation. A ra-

tional plan is needed - one that has been developed with input from the major partners in the health care system."[2]

'The New Directions for Management of the Health Care System' identified many potential issues for examination in the development of a comprehensive plan, such as - technological change, supply and distribution of physicians, flow of patients through the health care system, public education, allocation and delivery of hospital services, development of standards of care and ethical issues to name a few. These issues and more must be addressed one at a time in order that future growth of health services can be on the basis of rational planning; planning which evaluates and responds to priorities of need and not the demands or capabilities.

This report addresses one of these issues - the supply and distribution of physicians.

In April, 1987, the Minister responsible for the Hospital & Health Services Commission accepted an offer from the P.E.I. Medical Society to work in a cooperative effort in developing a physician resource plan. The Minister responded by requesting the establishment of a Committee to review and recommend on issues of medical resource requirements.

1.2 Committee Mandate

The Hospital & Health Services Commission in conjunction with the Medical Society, established a Medical Personnel Advisory Committee for the purpose of identifying and priorizing physicians supply needs. The objective would be to encourage the placement of new physicians where there is a need and to discourage physicians from locating where there is no obvious need. Discussions within this Committee would also focus on other opportunities where physicians could contribute to the management of the health care system.

The specific mandate of the Committee was to evaluate and recommend to the Hospital & Health Services Commission:

1. The optimum level and mix of physicians required on P.E.I;

2. The requirements for practitioners by community hospital;
3. The priority listing by which physicians should enter the province; and
4. The mechanisms to manage the flow of physicians entering the province.

1.3 Committee Composition

The Commission believes firmly that any success in the long term depends on the participation of those who have a stake in the end result. Many provinces have taken the route of not involving the physicians in the physician planning exercise, only to create alienation and frustration. Other provinces have not actively involved the hospitals in determining the extent of their professional requirements only to result in budgetary conflicts.

The Commission felt valuable information and concerns would be presented to the Committee by physicians, hospitals and the general public. To adequately respond to these concerns, equal representation was essential.

Therefore, the composition of the Committee was representatives from the Medical Society, the Hospital and Health Services Commission and the P.E.I. Hospital Association.

1.4 Process

The Committee approached the issue of physician supply from a provincial perspective. The Committee believed it was necessary to ensure all areas of the province were adequately heard. This was met by requesting hospital boards to consider their physician requirements for their representative communities.

The hospital structure was used as the focal point because it is the logical location in determining specialty numbers. In addition, many new family physicians see the out patient department of a hospital as the method of building up their practice.

Although family doctors are community based, their patients require the needs provided by hospitals either directly (out patient department, diagnostic procedures) or indirectly by services provided by their specialty colleagues.

The Committee invited the Medical Society, representing the views of Island physicians, to respond to the issues of physician supply, distribution, recruitment and management. A number of specialties made presentations to the Committee in particular, the P.E.I. Psychiatric Association and the College of Family Physicians. The Medical Society also recognized that many of their concerns would be identified by physicians during presentations to the Committee.

The Medical Personnel Advisory Committee invited written submissions from the public at large and was most pleased to have received a number of submissions from individuals, groups and communities.

2. CURRENT PHYSICIAN COMPLEMENT

The Committee reviewed the profile of physicians currently in practice in an effort to understand how needs are presently being met.

To accurately present this data, it was necessary to define a full-time and part-time physician. From this data, ratios of physicians to population were developed. Issues that impact on future needs, such as attrition and the provision of services, were also reviewed.

It is important to recognize that the physician complement changes rapidly and in cases of specialties a change of one can have a major impact. For the purpose of this study the physician profile is as of January 1, 1988.

2.1 Full-Time and Part-Time Physicians

The Committee proceeded to define a full-time and a part-time physician. It was agreed that part-time would be defined as less than 50% of the mean income for that specialty. For those specialties other than family practice, the mean income is the average income of those physicians who did not obviously distort the average. For instance, a new physician with less than a year's practice would distort the average of that specialty, so they would be excluded from the determination of the average. The mean income for family physicians was determined by eliminating two standard deviations from the mean. All those with payments of less than 50% of that mean are considered part-time. Table 1 summarizes the provincial physician complement by specialty.

The Committee felt it was necessary to assess the impact of part-time physicians on the delivery of services. To do so, the accumulated earnings of part-time physicians were converted into full-time equivalent earnings based on one-half of the average income for that specialty. The Committee recognized the importance of part-time physicians who are providing essential services to many parts of the province. Table II identifies the location of these part-time physicians.

2.2 Ratios

In reviewing the current complement of physicians on Prince Edward Island, the Committee considered how well it met the national established ratios of physicians to population. Table III compares these ratios to the established practices on Prince Edward Island. While there is merit in looking at the ratios, it is felt that ratios considered alone are inappropriate, particularly in such a compact geographical area as Prince Edward Island.

2.3 Attrition

While looking at the current complement, it is important to determine what the province's physician replacement needs would be in 5 years, if based on the current full-time physicians who may opt for practice slowdown or retirement.

Table IV examines the attrition rate by area and specialty through the identification of all those physicians who will be 65 years of age or over by 1993. This does not account for illnesses or for physicians leaving the province.

Replacement needs based on attrition only, would suggest the following requirements in the next 5 years:

Family Practice	- 7
Anesthesia	- 2
General Surgery	- 1
Internal Medicine	- 2
Obs/Gyn	- 3
Otolaryngology	- 1
Psychiatry	- 1
Pathology	- 1
Radiology	- 1
	19

2.4 Services Analysis

The provision of services varies from physician to physician, from one specialty area to another and from community to community. Table V illustrates the serv-

ices provided to residents of each of the seven hospital catchment areas, by family physicians and by specialists. The variation in services by catchment area could be interpreted as:

- under/over supply of physicians,
- type of population, demanding more or less services, or
- patient demand, not related to significant disease.

Table VI identifies the ratio of services to the number of residents seen by a specialty group. The variations with each group could be attributed to:

- over-servicing/under-servicing in specific geographic areas, or
- undersupply of specialties within a geographic area.

The Committee did not attempt to interpret the information on provision of services nor did it allow this information to influence any decision made on physician supply. While this information is limited, it is sufficient to suggest that a major analysis should be done jointly by the providers of services and the Commission in order to better understand what is happening. It raises a number of questions such as:

- What is the impact of consumer (patient) demand,
- To what extent are services influenced by the provider (physician),
- What pressures are exercised by the community,
- How comprehensive is peer review and standards of practice.

2.5 Community Initiatives

In discussions with hospitals and physicians, the Committee found that community initiatives, on the part of current physicians, was abundant.

The Committee heard that physicians provide office hours on a regular basis to areas of the province, such as Belfast, Morell and Wellington as an outreach service to that community.

Many communities are fortunate to have physician office hours in the evening. It is commendable that doctors, in some communities, are willing to have evening hours with so few to share the load.

Doctors are also recognized for their contribution to manor coverage, addictions and to the many hours of committee work both in the hospital and in the community.

TABLE 1
CURRENT PHYSICIAN COMPLEMENT

	Full-time	Part-time	Full-time Equivalent
Family Practice	65	19	72
Anesthesia	7	--	7
General Surgery	6	--	6
Internal Medicine	9	1	9
Obs/Gyn	7	1	7
Ophthalmology	3	1	3
Orthopedic Surgery	3	--	3
Otolaryngology	3	--	3
Pediatrics	3	1	3
Psychiatry	7	1	7
Urology	2	--	2
Dermatology	1	--	1
Physical Medicine	1	--	1
Oncology	1	--	1
Pathology	3	2	4
Radiology	5	1	5
Plastics	2	--	2
	128	27	136

NOTE: 1. Family Physicians, who practice in a specialty area, where over 50% of their earnings are derived from that specialty are accounted for in a specialty group. Specialists who have over 50% of their earnings derived from family practice are accounted for as family physicians.

2. Full-time equivalent is determined by the accumulated earnings of all those part-time physicians divided by one-half of the mean income in that specialty.

TABLE II
LOCATION OF PHYSICIANS BY HOSPITAL

SPECIALTY	QUEEN ELIZABETH			PRINCE COUNTY			COMMUNITY			KING'S COUNTY			WESTERN			SOURIS			STEWART MEMORIAL			TOTALS		
	FT	PT	FT EQ.	FT	PT	FT EQ.	FT	PT	FT EQ.	FT	PT	FT EQ.	FT	PT	FT EQ.	FT	PT	FT EQ.	FT	PT	FT EQ.	FT	PT	FT EQ
Family Practice	32	10	36	15	4	17	3	2	4	7	-	7	3	2	3	3	-	3	2	1	2	65	19	72
Anaesthesia	5	-	5	2	-	2																7	-	7
General Surgery	4	-	4	2	-	2																6	-	6
Internal Medicine	8	1	8	1	-	1																9	1	9
Obs/Gyn	5	1	5	2	-	2																7	1	7
Ophthalmology	3	1	3	-	-	-																3	1	3
Orthopedic Surgery	3	-	3	-	-	-																3	-	3
Otolaryngology	2	-	2	1	-	1																3	-	3
Pediatrics	2	1	2	1	-	1																3	1	3
Psychiatry	5	1	5	2	0	2																7	1	7
Urology	2	-	2	-	-	-																2	-	2
Dermatology	1	-	1	-	-	-																1	-	1
Physical Medicine	1	-	1	-	-	-																1	-	1
Oncology	1	-	1	-	-	-																1	-	1
Pathology	3	2	4	-	-	-																3	2	4
Radiology	4	-	4	1	1	1																5	1	5
Plastics	2	-	2	-	-	-	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	-	2
	83	17	88	27	5	29	3	2	4	7	-	7	3	2	3	3	-	3	2	1	2	128	27	136

TABLE III

RATIOS - PHYSICIANS TO POPULATION

	Full-Time Physicians	National Ratio
Family Physicians		
Queen Elizabeth Hospital	1:1,984	1:1,307
Prince County Hospital	1:2,071	1:1,307
Kings County Hospital	1:1,642	1:1,307
Souris Hospital	1:2,100	1:1,307
Western Hospital	1:3,250	1:1,307
Community Hospital	1:2,333	1:1,307
Stewart Memorial Hospital	1:1,500	1:1,307
Specialists		
Urology	1:63,400	1:56,464
Pathology	1:31,700	1:28,792
Dermatology		1:77,098
Physical Medicine		1:113,758
Radiology	1:42,266	1:17,449
Obs/Gyn	1:18,114	1:18,074
E.N.T.	1:42,266	1:51,456
Ophthalmology	1:63,400	1:30,099
Pediatrics	1:25,360	1:19,355
Orthopedics	1:42,266	1:34,127
Plastic Surgery	1:63,400	1:107,938
Anesthesia	1:18,114	1:13,805
Psychiatry	1:18,114	1:10,232
Internal Medicine	1:14,088	1:8,166
Surgery	1:21,133	1:12,292

Population by Cachment Area

Queen Elizabeth Hospital	- 63,500
Prince County Hospital	- 29,000
Western Hospital	- 6,500
Community Hospital	- 7,000
Stewart Memorial Hospital	- 3,000
Kings Co. Mem. Hospital	- 11,500
Souris Hospital	- 6,300
Total Population	126,800

TABLE IV
IMPACT OF ATTRITION ON CURRENT PHYSICIANS

SPECIALTY	QUEEN ELIZABETH		PRINCE COUNTY		COMMUNITY		KING'S COUNTY		WESTERN		SOURIS		STEWART MEMORIAL		TOTAL	
	CURRENT	1993	CURRENT	1993	CURRENT	1993	CURRENT	1993	CURRENT	1993	CURRENT	1993	CURRENT	1993	CURRENT	1
Family Practice	32	5	15	1	3	0	7	1	3	0	3	0	2	0	65	
Anesthesia	5	2	2	-											7	
General Surgery	4	1	2	-											6	
Internal Medicine	8	2	1	-											9	
Obs/Gyn	5	2	2	1											7	
Ophthalmology	3	-	-	-											3	
Orthopedic Surgery	3	-	-	-											3	
Otolaryngology	2	1	1	-											3	
Pediatrics	2	-	1	-											3	
Psychiatry	5	1	2	-											7	
Urology	2	-	-	-											2	
Dermatology	1	-	-	-											1	
Physical Medicine	1	-	-	-											1	
Oncology	1	-	-	-											1	
Pathology	3	1	-	-											3	
Radiology	4	1	1	-											5	
Plastics	2	-													2	
	83	16	27	2	3	-	7	1	3	-	3	-	2	-	128	

NOTE: 1. Current Physicians Represent Full-time Physicians Only
2. Attrition is based on these physicians who will be 65 years and over in 5 years.

TABLE V

SERVICES/POPULATION *

Hospital Catchment Area	Services by G.P./pop.	Services by Specialist/pop	Total Serv per pop.
Queen Elizabeth Hospital	3.56	1.73	5.27
Kings Co. Hospital	3.82	1.27	5.09
Souris Hospital	3.64	1.47	5.12
Prince County Hospital	4.10	1.60	5.70
Stewart Memorial Hospital	4.93	1.13	6.06
Community Hospital *2	4.80	1.25	6.05
Western Hospital *2	4.95	1.07	6.02
Provincial	3.88	1.57	5.46

* NOTE: These ratios use services provided in a nine month period.

There may be some distortion in the catchment areas for Community and Western Hospitals. The ratio for that area may be better represented if they were combined.

Population catchment areas by hospital - # of population.

TABLE VI

RATIO OF SERVICES PER RESIDENT SEEN

Specialty	# of Services	# of Residents Seen	Ratio of Services/ Res. Seen	# of FT Physician 1 service or more over aver
Family Practice	491,750	160,120	3.07	18
Anesthesia	20,469	7,060	2.90	1
General Surgery	19,047	7,197	2.65	1
Internal Medicine	67,829	24,260	2.80	1
Obs/Gyn	27,420	8,976	3.05	1
Ophthalmology	8,595	4,709	1.82	-
Orthopedic Surgery	12,052	4,786	2.52	-
Otolaryngology	13,486	5,671	2.38	-
Pediatrics	12,401	3,293	3.77	1
Psychiatry	21,451	2,313	9.27	2
Urology	4,607	1,715	2.69	-
Dermatology	4,581	1,948	2.35	-
Plastics	4,696	2,611	1.80	-
Physical Medicine	-	-	-	-
Oncology	-	-	-	-
Pathology	-	-	-	-
Radiology	-	-	-	-

NOTE: Figures used reflect nine months of service

3. SUMMARY OF REQUESTS

The Committee heard presentations from many organizations, including all hospitals and a variety of professional associations. The names of these presentors are listed in Appendix I. In addition, the Committee invited written submissions from the public and Appendix II lists those submissions.

The Committee believed this approach would provide valuable information for the determination of physician requirements. This information is summarized in Table VII, as the requests for physician needs. A more detailed description of these requests is outlined by specialty in this section. It must be emphasized that these requirements are based on a perception of need, as expressed by the presentors.

3.1 Family Practice

The Committee heard statements on the requirements for family physicians from all the hospitals, as well as, from the College of Family Physicians.

The College of Family Physicians believes that "hospital's requirements have no direct bearing on the number of Family Practitioners required to work in any given community and that data obtained from hospitals may therefore be misleading".[3] The College further feels that there is not an over supply of family physicians and rather than identify a specific requirement, they favor the current marketplace approach as the method of managing medical manpower. The College believes that "further study is necessary to be sure that currently perceived medical manpower estimates take into consideration the rapidly changing needs and demands of the population as well as the long term range of services to be provided in any particular community...while receiving professional fulfillment and the freedom to participate and contribute to a wider range of community services."[4]

In the area of family physician requirements the present complement was accepted as satisfactorily meeting the needs of the Queen Elizabeth Hospital, Prince County Hospital, and the Kings County Memorial Hospital catchment areas. The Committee did receive requests from the communities of Sherwood and Crapaud to consider specific requirements for those areas.

The Community Hospital identified an immediate need for a family physician with specialty in anesthesia, and a second family physician within two years.

Souris Hospital, while satisfied with their current complement, expressed the desire for a female physician. They felt a female family physician would attract a segment of their residents who now go to Charlottetown for medical services, particularly for obstetrical care.

The Stewart Memorial Hospital identified requirements for three family physicians to meet the demand for on-call services. Their current complement is 2.5 physicians.

Western Hospital expressed an immediate need for one additional family physician with the possibility of another physician within one to two years.

Although the Medical Personnel Committee did not hear any specific requirements for bilingual physicians, there are parts of the Province where French is the predominant language. The Committee believes any physician resource plan must be cognizant of this need.

3.2 Lab Medicine

A review of the provincial laboratory system with the result of an expansion at Prince County Hospital lab has established a requirement for a pathologist in that hospital. The Queen Elizabeth Hospital identified the need for 2.5 more pathologists, particularly in the areas of medical microbiology, pathology and hematology.

3.3 Radiology

The Queen Elizabeth Hospital expressed an immediate need for another radiologist, particularly with special training in vascular radiology. They also identified a requirement for an additional radiologist when the CT Scanner is operational.

Prince County Hospital established a requirement for an additional full-time radiologist to increase their complement to two. Western Hospital requested there be a full-time radiologist dedicated to the three western hospitals which could be included in the Prince County Hospital complement.

3.4 Physical Medicine

The Queen Elizabeth Hospital recommended a further physiatrist be recruited with particular training in electromyography and neuro-rehabilitation.

3.5 Psychiatry

The P.E.I. Psychiatric Association submitted a brief to the Committee outlining in considerable detail, the requirements for psychiatric manpower in the Province which, based on their assessment, includes

- a Director of Mental Health and Physician-in Chief at Hillsborough Hospital,
- Two full-time psychiatrists at Hillsborough Hospital in addition to a physician-in-chief,
- Four full-time psychiatrists for services at Q.E.H. as well as for general practice,
- One full-time psychiatrist for Richmond Centre Mental Health Clinic and McGill Day Hospital,
- Three psychiatrists for P.C.H. encompassing the western part of the province,
- One psychiatrist for the Souris/Montague area, and
- Three child and adolescent psychiatrists to respond to this expanding area of need.

One area where the need for psychiatrists has not been satisfactorily examined is Addiction Services. However, Psychiatry Services were noted as a deficiency by every hospital and by the Department of Health and Social Services. To document their requirements would be to reiterate the requirements as identified by the Prince Edward Island Psychiatric Association.

3.6 General Surgery

No new requirements have been identified for general surgery. (Note 3.7)

3.7 Orthopedics

Prince County Hospital believes it is necessary to increase their complement of surgeons to three (presently two). It is their feeling that the third surgeon should be an orthopedic surgeon. In the event this does not transpire, their requirements would be for a general surgeon.

3.8 Otolaryngology

While no specific requirement was indicated, Otolaryngology was identified by the Medical Society as an area of need.

3.9 Ophthalmology

The need was expressed by Prince County Hospital and Queen Elizabeth Hospital that four Ophthalmologists in total, which would mean the recruitment of one more, is required to meet the needs of Islanders. An individual from the Richmond area identified the need for an ophthalmologist in the Summerside area.

3.10 Plastics

No further requirements were identified for plastic surgeons.

3.11 Pediatrics

The Queen Elizabeth Hospital believes there is a requirement for an additional pediatrician specializing in neonatal intensive care.

As well, the Prince County Hospital identified a need for another pediatrician.

3.12 Obstetrics/Gynecology

The Queen Elizabeth Hospital expressed a need for another obstetrician/gynecologist.

An individual from the Summerside area expressed a need for a female gynecologist for Prince County Hospital.

3.13 Internists

Prince County Hospital identified an immediate need for an additional internist for their area. In addition, Community Hospital has expressed the need for a full-time internist based in O'Leary on a full-time basis.

While the Queen Elizabeth Hospital feels their complement meets their needs, they believe that the next recruited internist should have nephrology training.

3.14 Oncology

The Canadian Cancer Society presented a submission which identified the provincial need for three oncologists - two oncology specialists and a radiation oncologist. The Medical Society also expressed the need for further recruitment in the area of medical oncology.

3.15 Dermatology

No further need was identified.

3.16 Anesthesia

Queen Elizabeth Hospital identified a requirement for 5 equivalent anesthetists, one more than their current complement. The possibility for three anesthetists being required in the next five years was also noted.

3.17 Urology

No further requirements were identified.

3.18 Neurology

The need for a neurologist was expressed by many hospitals. The Queen Elizabeth Hospital believes a neurologist is required when the CT Scanner is operational. In addition, the Medical Society, the Prince Edward Island Association for Community Living, the Council of the Disabled and Epilepsy Prince Edward Island have identified neurology services as a requirement for P.E.I.

3.19 Neurosurgery

The Queen Elizabeth Hospital believes a neurosurgeon is required when the CT Scanner equipment is acquired.

3.20 Gerontology

The Medical Society and the Queen Elizabeth Hospital identified recruitment requirements in the area of geriatric medicine. Many communities expressed an interest in being better equipped with a philosophy of geriatric care.

3.21 Allergist

The Allergy and Environmental Illness Group has identified a need on Prince Edward Island for an allergist. This area was identified by others as having a requirement for services to be made available to Islanders.

3.22 Public Health

The Medical Society and the Department of Health and Social Services identified the need for a full-time Public Health Officer who would have particular interest in epidemiology.

3.23 Emergency Medicine

The Medical Society identified a recruitment need for an emergency medicine specialist at the Queen Elizabeth Hospital.

TABLE VII
REQUESTS FOR PHYSICIAN NEEDS

Specialty	FT Equivalent	Requested Increase in complement
Family Practice	72	6
Anesthesia	7	1
General Surgery	6	--
Internal Medicine	9	2
Obs/Gyn	7	2
Ophthalmology	3	1
Orthopedic Surgery	3	1
Otolaryngology	3	--
Pediatrics	3	1
Psychiatry	7	8
Urology	2	--
Dermatology	1	--
Physical Medicine	1	1
Oncology	1	1
Pathology	4	3.5
Radiology	5	3
Plastics	2	--
Neurology	--	1
Neurosurgeon	--	1
Gerontologist	--	1
Allergist	--	1
Public Health	1	1
Emergency Medicine	--	1

4. ISSUES IMPACTING ON PHYSICIAN SUPPLY

The Committee identified a number of areas that impact on physician supply requirements. The Committee believed it was necessary to address these issues before determining the appropriate physician complement. These issues, as described by this section, are:

(1) delivery of services
(2) technology
(3) role of the female physician
(4) the aging population
(5) public education
(6) role of the family physician
(7) concept of provincial services

4.1 Delivery of Services

The Committee reviewed such issues as out-of-province referrals, out-patient clinics, primary care services and alternative delivery methods. The following sections reflect the findings on these issues.

4.1.1 Out-of-Province Referral Services

The Committee reviewed the pattern of referrals to out-of-province specialists in an attempt to understand if a requirement existed for a physician to be located here in a new specialty area. Table VIII illustrates the referral pattern in the last four years, based on diagnostic groupings.

Total referrals continue to decline, although at a slower pace than in previous years. Declines in referrals are obvious where Prince Edward Island has gained in a specialty area - ie. diseases of the Genitourinary System and diseases of Skin and Subcutaneous Tissues. Other specialty areas which question the rationale for referrals are diseases of the Nervous System and Sense Organs, diseases of the Circulatory System and diseases of the Musculoskeletal System and Connective Tissue. However, the data was in such an unrefined fashion that there could be no conclusive evidence that, by recruiting a particular specialist referrals would not happen nor that it would be cost effective in the long term.

With regard to referrals, a further review revealed that of the twelve physicians who had the most referrals, seven of these physicians are family physicians. During it's travels, the Committee found the Commission did little to enforce any consistent policy for out-of-province referrals. Because of this, referrals have been allowed even without local specialty consultation.

Many physicians expressed the opinion that if a policy was more rigidly and consistently applied it would help them in discussing alternatives with their patients.

In addition, it was discovered that detailed analysis on out-of-province referrals was difficult at this time due to the method of storing the data. The Committee concluded that further study and review was required in this area.

4.1.2 Out-Patient Clinics

A growing phenomenon is the presence of specialty clinics in the community hospitals. This is particularly evident in the western part of the province. Table IX summarizes the types and frequency of out-patient clinics held in each hospital.

There is an obvious impact on physician supply by this form of delivery of service. However, the Committee is not comfortable with the proliferation of this practice because there are too many unanswered questions, such as - who is the prime initiator, who is benefiting, where is the best location if these clinics are to continue - hospital or clinic, what types of services are being offered, and what volume of service is being delivered.

The Committee concluded that a more detailed study on out-patient clinics was required to assess their impact on physician manpower requirements.

The Queen Elizabeth Hospital also provides a setting for out-patient clinics. Specialists within the hospital offer day clinics and the hospital provides the facility for the location of specialists from out-of-province who provide services through a clinic arrangement. Appendix 3 summarizes the types of out-of-province clinics provided through the Queen Elizabeth Hospital.

The Committee did not evaluate the need for new clinics nor the cost/benefit effectiveness of these out-of-province clinics but concluded that further assessment and evaluation of their use should be undertaken.

4.1.3 Delivery of Primary Care Services

The Committee heard with great consistency, not only from the College of Family Physicians, but from many individual general practitioners, that some services are being provided by specialists which should be provided by family physicians.

The most common service areas are: annual health exam and pap tests being done by gynecologists, well baby care being provided by pediatricians, and normal obstetrics by obstetricians.

Although this practice has come about for a variety of reasons, such as - patient preference, build-up of physician practice and litigation considerations, it is the considered opinion of the Committee that it is unnecessary to have these services provided by specialists. The irony of the situation is as one physician put it "The child is seen in Charlottetown by the pediatrician when she is well, but when the child is sick, she is seen by me" (rural G.P.).

The Committee believes there are a number of alternatives to this situation. In order to change this pattern of flow, more emphasis must be placed on the need for physician education as well as for patient education. Consideration may also be given to the establishment of a joint family physician and consultant specialty service.

Efforts to identify how changes can come about so that the delivery of primary services returns to and remains with the family physician must be considered jointly with the Medical Society.

4.1.4 Alternative Delivery Methods

The Committee examined the physician role of delivering services in other than the traditional settings, that is the hospital or the office.

The College of Family Physicians indicated that "In the future the most limited resource will be the expensive institutional bed. This constraint is forcing change in our delivery system and leading to alternatives such as the extramural hospital concept and the concept of having more investigations and procedures done as an out-patient. Family practitioners will and should become more involved in the coordination of these efforts."[5]

The extramural concept and the alternative of home care have been received very favorably as alternative delivery methods. However, physicians feel that if these methods are to be used to seriously alter the delivery of services, fee for service is an inappropriate mechanism of remuneration. Alternative mechanisms will need to be developed if it is going to be successfully managed by medical practitioners.

4.1.5 Delivery of Medical/Health Services by Alternative Professions

While at one end of the spectrum, physicians see themselves specializing and sub-specializing, at the other end, there are alternative health professionals providing other health services. These services may have been performed by physicians in the past or they may be independent of physician practices.

The Committee looked at the concept of nurse practitioners, and while there are many positive points, particularly for those areas of the country where there is geographical isolation, it is felt that a nurse practitioner would not play a significant role on Prince Edward Island in the near future.

With regard to nurses in other delivery modes the Committee believes the nurse working in the office setting can be further challenged to complement the medical practitioner. There are a number of medical duties the nurse could do, or is doing, to free the physician for other responsibilities.

The Committee also discussed the merits of a midwifery system on Prince Edward Island. A number of other provinces are establishing midwifery services and giving it legal status. If obstetricians become difficult to attract and family physicians continue to turn away from normal obstetrics, then it is the

opinion of the Committee that midwives can, in conjunction with an obstetrician or family physician provide a very good and safe service to Island families.

There is a broad range of health services being provided to Island residents through components of the Department of Health and Social Services. The Committee heard, that while the services provided are important, often the family physicians feel the continuity of care is broken because the doctor does not have a total picture of the patient's care.

Some physicians believe that programs such as the 3 1/2 year assessment, a program established to assess a child's development at 3 1/2 years, have the potential of creating visits to physicians, to reaffirm what they have been told or to get a referral to a specialist for a problem identified by the public health nurse. From it's limited perspective, the Committee believes this program is worthwhile. However, there is a need to work more closely with the medical profession in the development and ongoing monitoring of health programs, with this program needing particular attention.

Physicians are very responsive to the home care and support program. The program's limitations were noted, but the experience of those doctors who use the service is favorable. Concern was expressed about the time required from a physicians' work day in receiving calls and discussing home care patients. This component is considered a disincentive for many physicians and alternative mechanisms of communication or payment would have to investigated.

4.2 Technology

The advancements in technology are impacting on every component of the health care system from ethical issues to budgetary concerns.

There is no doubt that technological advances change the requirements for physicians. However, there are a number of conflicting opinions relative to that impact.

In a Physician Manpower Requirements document prepared by the U.S. Department of Health, Education and Welfare which researched the impact of technology it stated: "Technological advances have not only fostered physician specialists but according to J. Maxmim, may

make doctors obsolete in the 21st Century. He advocates and predicts that expanding technology together with a political, economic, social and psychohistorical forces...will culminate in the obsolescence of the physician and the establishment of a medic-computer model of health care delivery.

At the other extreme, perhaps, is the view of McClure at Interstudy, that the medical care system can legitimately absorb every dollar society will make available to it. One can infer from his remarks that since physicians play a large role in directing those dollars, it would seem that the profession might grow in numbers in proportion to dollars available."[6]

In yet another study on Physician Manpower Forecasting in Canada by J. Lomas and G. Stoddard, they suggest that, "Technological advances continue to increase physician productivity, such that one physician in 1980 may be equivalent in workload to, say, only 0.75 of a physician in 1990."[7]

The Committee did not take a position on the extent to which technology will affect physician numbers but concluded it is important to recognize that technological advances will have its impact. Not only will it impact on physician supply, but also on the service delivery system, the financial arrangements and consumer behavior.

4.3 Role of the Female Physician

Considerable attention has been placed on the impact a growing number of female physicians will have on the supply needs for physicians and in the patterns of health care delivery in the future.

The literature on the productivity of the female physician appears to suggest that the female physician has between 65-70% of the productivity of a male physician measured in work performed (measured in time) over a lifetime.

Dr. Jock Murray put this pattern of practice in perspective by suggesting "Did we really believe that the bizarre pattern of long hours (often 70-80 hours per week) practiced by many physicians was good for the personal life of the physician, the spouse, the

children or, in the long run, good for their patients?...Women in medicine are leading the way in making this positive change."[8]

On Prince Edward Island there are 19 full-time and part-time female physicians which represent 12.2% of all practicing physicians. Unquestionably, this number will increase as we see more females graduate from medical school.

With respect to the apparent 'bizarre' work ethic employed by many physicians, there is evidence that recent male graduates, as well, are recognizing that this workload is no longer necessary or appropriate and are adjusting their work practice. Therefore, although it is important to understand the impact the supply of female physicians will have on the current volume of work performed, the Committee concluded it is more important to understand how male and female physicians differ in their patterns of practice and uses of the health care system.

A study conducted by Joel Babula of Applied Management Services suggested that "the number of practicing female physicians could be expected to have an effect on the manner in which physicians organize their practices in the future and also on the future supply of physicians' services. For example, physicians in the future may be willing to practice in less traditional organizational settings and to be reimbursed in a different manner than the traditional solo, fee-for-services system."[9]

While there is no clear evidence, some would suggest that female physicians practice a different type of medicine and apply medical technology in a fashion unlike their male counterparts. Therefore it could be assumed this would have a resulting effect on patients.

4.4 IMPACT OF THE AGING POPULATION

Many public documents such as Health, a Need for Redirection, Achieving Health for All: A framework For Health Promotion and the CMA's Health Care for the Elderly clearly articulate the issues facing the health care system as a result of changing demographics.

The conclusions reached by demographic projections are consistent. The absolute numbers of elderly persons will more than double by 2021.

There is no question that the elderly require services unique to other sectors but the extent of the impact of demographics alone on health care services is still a debate. Robert G. Evans, in an article in Canadian Public Policy looked at the impact of aging on the utilization or growth in services. He found that "age-specific per capita utilization among the elderly is rising relative to that of the non-elderly...The increasing health care utilization of the elderly population is real; but it is as a result, not primarily of the increase in their numbers, but of the changing patterns of servicing which they are receiving... Population aging requires a redeployment of resources, at least in relative terms away from physicians' services and over to what the British call the "Cinderella services" long term care, home care, mental health - where aging is having a significant impact on needs."[10]

Rather than the elderly greatly affecting physicians or physician numbers the question is how and with what affect does the physician have on the elderly.

The goal of the Canadian Medical Association Committee on Health Care for the Elderly was "to assist its peers to evaluate values and attitudes toward the elderly."[11] The report states that "Doctors in Canada must be prepared to influence public policy with regard to the total health care needs of the elderly and to be their advocates in seeking to have these needs met."[12]

The Medical Personnel Committee posed the question to many physicians of the adequacy and appropriateness of services to the elderly. While a number of physicians felt they were not or could not meet the total needs of the elderly and therefore would welcome further education, other physicians felt they were adequately meeting the expressed need. The Canadian Medical Association report recommends that a continuum of care is required and that it is not only the role, but the responsibility of the physician, for the coordination of that care.

The Medical Personnel Committee supported this position and would encourage the Medical Society to work with health professionals toward the development of a continuum of care for our elderly.

The Committee recognized that in all areas of medicine, continuing education plays a very important role. A number of physicians identified the availability of appropriate continuing education as a problem but many more felt the pressure of leaving practice was a much greater deterrent.

Rural physicians have difficulty leaving their practice for an educational seminar and many physicians hesitate to close their office for an extended period, to travel to a center that has specific continuing educational programs. As unique issues develop, such as services to the elderly, programs should be sought out and with the advances in current communication technology, brought to doctors in their community.

The Committee concluded that innovative models should be explored for the purposes of providing physicians with continuing education programs within their community setting.

4.5 PUBLIC EDUCATION

The health care system has reached out and provided many cures and many success stories, therefore selling its potential and its capabilities. The result has been an awareness and an education of individuals to not only what is available to them, but also what they should receive.

It is uncertain how great an impact this education is having on the system, but it was suggested that it is both positive and negative.

It is important that individuals better understand the health care system so they can be informed users and can make good choices for their health care. Conversely, partial education or misdirected education can create unrealistic expectations and inappropriate demands on the system.

The Committee believed that efforts must be made to better inform residents that the health care system is far from "free", with there being a limit to funding and people have to make responsible choices in the use of services.

The Committee concluded that an awareness program should be developed to better inform Island residents on the use and cost of the health system.

There is also evidence that education by some lobby or special interest groups is in fact increasing the demand by creating an expectation for a service. While this may not always be inappropriate, the Committee concluded there should be greater coordination in the development of educational material among all those who might be affected by an educational program.

What health education has also done is alerted people to the importance of a healthy lifestyle and to the hazards of unhealthy habits. There is increasing evidence that people are ready to switch from a concept of health care based on sickness to a pursuit of wellness. However, the programs aimed at health promotion have not been considered overly successful and implementation is slow. It is now clear that the major killers in our society are those which we have control over, including - alcohol, smoking, accidents, suicide and drugs. Considerable work must be done in understanding what measures will work to better promote health and to reach those groups at risk. What is clear is that physicians must play a continuing role in life style counseling. The Committee suggested that the Commission work closely with the Medical Society in understanding the role of counseling in their profession and how it can better meet the needs of identified risk groups.

4.6 ROLE OF FAMILY PHYSICIAN

The Family Physician performs many aspects of home, community and institutional care including office visits with daytime and evening hours, home visits, hospital work of all sorts, intensive care, emergency services, anesthesia, surgery, obstetrics, nursing home care, chronic care, rehabilitation and addiction services.

As documented in Section 4.1.3 of this report, there are specific services which the traditional family physician should be providing which, for the most part, are now provided by specialists. Those identified to the Committee include:

annual health exam
pap test
well baby care, and
normal obstetrics

The College of Family Physicians sees "the evolving trend and the way of the future will be for Family Physicians to maintain their position as the first contact for patients in the health care system...Family Physicians will be more involved in home care and will take on extramural hospital responsibilities...As well Family Practitioners, re-emphasizing their traditional role, will also broaden their base in prevention and health education and also chronic institutional and hospital care. As well, some family Physicians will move into the areas of addiction services, psychotherapy and counseling on family dynamics and gerontology."[13]

It has been identified by the College of Family Physicians that their members are involved in the delivery of many facets of specialty services. This has contributed greatly to the prevention of potential deficiencies in medical human resource requirements. The Committee concluded that a family physician, with an interest in a particular field and with appropriate additional training can offer a service where there may now be a deficiency. To an extent this is happening where a few physicians are showing an interest in psychotherapy. With a lack of psychiatrists this practice can provide tremendous support. Another area where the Committee recognizes the requirement for an individual with particular interest and concentrated skills and teaching ability is in the delivery of geriatric medicine. The Committee would encourage family physicians to look at this "sub-specialization" approach and to pursue interests with specialty groups.

The Committee firmly believed that the continuity of treatment for an individual, by all health professionals, must have a base which must be with the family physician.

The College of Family Physicians identified themselves as the willing and natural leader of the team of health professionals delivering services to an individual. The Committee concluded that these leadership qualities be challenged to provide better services and integration of related health service professionals.

4.7 Concept of Provincial Services

The Committee reviewed the delivery of hospital and medical services, from the perspective of how efficiently and effectively it works, considering the quantity of physicians available.

The Committee felt there should be some consideration to the establishment of provincial services, particularly for those which are now fragmented with some component available within each of the hospitals.

It was the view of the Committee that at least 3 areas are appropriate for a provincial service concept: lab services, radiology and psychiatry.

(a) Laboratory

While the lab system is presently considered a provincial service, from many sectors it is felt that it has not met that objective. Community hospitals look toward the provincial lab system for continued education for hospital laboratory personnel. Rural physicians expect hospitals can continue to provide and expand the delivery of diagnostic services at a local level with the assistance and guidance of a care group of pathologists.

(b) Radiology

The provision of radiology services did not appear to be a problem in the western part of the province. With the limited number of radiologists available at Queen Elizabeth Hospital, hospitals in King's County are unsure of what future x-ray interpretation services will be available to them.

Technology continues to expand, particularly in the area of diagnostic devices. The Committee believed it was critical that any new growth in this area be mutually considered by the Commission and the hospital community.

The Committee concluded that Prince County Hospital be made responsible for the appropriate delivery of radiology services for the three western hospitals and that Queen Elizabeth Hospital be responsible for ensuring service to the two eastern hospitals.

(c) Psychiatric Services

The Committee heard many concerns about the delivery of psychiatric services. It was recognized that the most glaring problem is the current lack of psychiatrists but, as well, community mental health is minimal in a number of communities.

Many physicians are displeased with the mechanism required for admitting an individual to an alcoholic treatment unit. This is particularly a problem with the Queen Elizabeth Hospital Psychiatrists.

Concurrent with this Committees' work, the Department of Health and Social Services, along with representatives from many of the provider groups is assessing the delivery of mental health services. This review includes how facilities like Queen Elizabeth Hospital, Prince County Hospital and Hillsborough Hospital are used, the delivery of community mental health, aspects of the aging, youth and educational issues.

The Committee did not study in great depth the concept of a provincial psychiatric program. However, it was the Committees' opinion that a provincial perspective, in a time of limited resources, will create greater efficiency and effectiveness in the delivery of psychiatric services.

TABLE VIII
SUMMARY OF REFERRALS BY DIAGNOSTIC CATEGORY
1984 - 1987

Diagnostic Category	1984	1985	1986	1987
Infectious & Parasitic Diseases	30	29	19	23
Neoplasms	306	310	314	294
Endocrine, Nutritional, Metabolic and Immunity Disorders	123	69	63	75
Diseases of Blood & Blood Forming Organs	9	19	14	13
Mental Disorders	50	60	30	48
Diseases of Nervous System & Sense Organs	362	413	378	400
Diseases of Circulatory System	282	287	264	259
Diseases of Respiratory System	71	81	60	47
Diseases of Digestive System	79	117	128	146
Diseases of Genitourinary System	198	212	206	162
Complications of Pregnancy and Childbirth	29	25	19	16
Diseases of Skin and Subcutaneous Tissue	433	436	104	87
Diseases of Musculoskeletal System & Connective Tissue	202	249	248	229
Congenital Anomalies	81	116	125	102
Certain Conditions Originating in Perinatal Period	10	12	7	46
Symptoms, Signs and III Defined Conditions	358	385	346	335
Injury and Poisoning	112	169	139	112
TOTALS	2,735	2,989	2,464	2,394

TABLE IX
SPECIALTY CLINICS/OUT-PATIENT CLINICS

SPECIALTY	COMMUNITY	KING'S CO.	PRINCE CO.	SOURIS	STEWART MEM.	WESTERN
Orthopaedics	2-1/2 day/wk	2-1 even/2wk.	1 day/week	1 day/2 wk.	---	2-1/2 day/wk.
Paediatrics	1/2 day/2wk.	---	---	---	---	1/2 day/month
Psychiatry	1/2 day/wk.	1 day/wk.	---	---	---	1/2 day/month
Radiology	1/2 day/1-2 wk.	2-1/2 day/wk.	---	---	---	2-1/2 day/week
Internal Medicine	1/2 day/wk. 1 day/month	1/2 day/wk.	---	---	---	1 1/2 days/month
Surgery	---	---	---	---	---	1 day/week
Plastics	---	1/2 day/wk.	2 days/wk.	---	---	---
Oncology	---	---	1 day/wk.	---	---	---
Physical Medicine	---	---	1-2 days/month	---	---	---

5. PRIORIZATION OF NEEDS

The Committee recognized that some Hospital Boards were more successful than others in representing the broad range of communities their hospitals serve.

The Committee also recognized the problems facing particular communities and physicians with single physician coverage. The Committee felt ways must be found to alleviate these pressures without necessarily increasing physician numbers. The Committee would challenge the College of Family Physicians to take a lead, with the assistance of the Commission, in researching alternative coverage systems. The primary objective would be to maintain an efficient network of community family physicians.

The Committee reviewed the submissions made to it, and assessed the needs based on:

- the current complement in a particular hospital area relative to other areas,
- the total current complement within a specialty area,
- the impact of attrition,
- the impact in growth of services, and
- the ability to recruit.

In addition, the Committee assessed physician requirements from the perspective of the community hospital or primary care hospital needs and from the secondary and tertiary care hospital needs. The requirements as identified by the Committee are included in this section along with recruitment approaches.

5.1 Primary Care Hospital Needs

At the present time, the five primary care hospitals - Souris, Kings County Memorial, Stewart Memorial, Western and Community Hospitals provide similar services. It is understood that the role of the primary community hospital is evolving and therefore, its medical requirements. The Committee is not in a position to recommend physician requirements beyond the primary care role, but urges the Commission to proceed with its' plan of developing a comprehensive hospital delivery system. It is from that process that adjustments in specialty areas could be considered to primary care hospitals.

Having considered the requests, the Committee concluded that the Family Physician complement at Western Hospital be expanded by one. (This has already been accomplished) The Committee also concluded that the complement of Family Physicians at Community Hospital be expanded by one physician. The Committee was made aware that the Prince Edward Island Medical Society is participating with the Canadian Medical Association in the determination of training requirements for family physicians wishing to perform anesthesia. The Committee concluded that the criteria should become the necessary requirement in the granting of licenses for family physicians wishing to provide this service. Further, the Committee would recommend that Community Hospital not attract a family physician with specialty in anesthesia until the Canadian Medical Association Task Force has completed it's work.

There does not appear to be clear evidence at this time that the Souris Hospital area required another physician, but if the service pattern changes, consideration should be given at that time.

With respect to Stewart Memorial Hospital, the Committee accepted the need for assistance for additional coverage for this hospital. Therefore, the Committee concluded that mechanisms be immediately explored which would assist Stewart Memorial Hospital in this endeavor.

5.2 Secondary and Tertiary Care Needs

Physician requirements in specialty services are limited to Prince County Hospital and Queen Elizabeth Hospital.

The Committee cautioned that with a population base of 127,000 people, there exists a great possibility for duplication of services and inefficiencies if expertise in one specialty or sub-specialty built up in both hospitals.

The Committee concluded that during the development of the hospital delivery plan, consideration be given to identifying core specialty services which should be available in both hospitals and other specialties which should be established in specific locations as a center of excellence for that specialty.

At the present time, there are a number of identified needs within Prince County Hospital and the Queen Elizabeth Hospital.

The Committee concluded that the complement of Prince County Hospital be immediately expanded to include - another internist (accomplished), a psychiatrist, a pathologist, a general surgeon and a radiologist. The Committee recognized that the area of pediatrics at Prince County Hospital requires careful study. It is understood that the new Medical Director to the Hospital & Health Services Commission will play a much greater role in assisting hospitals in working out problem areas, advising physicians, and assessing physician workload.

The Committee concluded that the Medical Director of the Hospital and Health Services Commission should work with Prince County Hospital in developing options to the provision of pediatric coverage.

With regard to physician requirements at the Queen Elizabeth Hospital, the Committee concluded that specialty areas for the Queen Elizabeth Hospital be immediately expanded to include - 2 pathologists, a radiologist, a psychiatrist, a pediatrician, an oncologist, an emergency room physician and an anesthetist. With the acquisition of the CT Scanner, the Committee recognized that an eventual provision for a radiologist and a neurologist is evident.

The Committee further refined the priorization of physician requirements by identifying the immediate recruitment needs and those that can be addressed within the next five years.

The Committee concluded that immediate recruitment should commence in Otolaryngology (ENT), psychiatry, lab medicine and obstetrics. The Committee further concluded there should be recruitment within the next five years for anesthetists, radiologists and family physicians in those primary hospitals where need has been accepted.

Table X summarizes the recommended complement by specialty area, with the identified short term and long term recruitment requirements.

The short term or immediate requirements reflect those physicians which have already been identified in the preceding paragraphs or where attrition is already impacting on the supply of physicians. In regard to

psychiatry, the Committee did not identify a recommended complement because given such shortages and the Canadian situation with regard to availability, it is unlikely that we will experience an influx of psychiatrists even with considerable recruitment.

The long term or five year recruitment plan identifies those areas which will be affected by attrition and where a clear, long term requirement has been identified.

For those areas where there is a need for more than one physician, the Committee did not indicate where the first physician should be located. It is felt that when a decision is made to recruit a specialist, an analysis would be done to determine where the greatest need exists.

The Committee fully recognizes and cautions readers that the plan as identified can and will change with shifts in the supply and demand for physicians.

5.3 Recruitment Approaches

The availability of physicians in some specialties, lack of residency positions in other specialties, and availability of physicians for certain locations limits the opportunities Prince Edward Island has for a traditional recruitment process.

The Committee concluded that a formal and aggressive recruitment process be put in place which would target the recruitment and training to the needs of Prince Edward Island.

There are a number of opportunities where the Committee felt attention should be focused in this area:

1. Establish a liaison with medical students. There are at least 35 Island students in some level of training at various medical schools. The Committee concludes that the physician resource plan should be circulated and discussed with all Island students presently in medical school. As well, the Medical Society and the Hospital and Health Services Commission should annually discuss future opportunities with students entering the medical program and encourage them to focus their training in areas of need.

2. It has been documented that there are locations within the province where it is difficult to attract physicians. The Committee concluded that it is necessary to establish incentives, such as using a sessional fee or salaried basis to encourage physicians to locate in those areas.

3. The suggestion was made to the Committee that within a recruitment process the concept of packaging should be considered. For example, rather than attracting a general internist, we ensure that a physician is carrying some training in a sub-specialty area where the province is presently deficient.

4. The Committee understood that the Province presently pays Dalhousie University $90,000 a year as compensation for residency training. The Province has not had the opportunity to designate that $90,000 toward specific residency positions, nor have Island students recognized that in fact the Province is contributing to their program.

   The Committee concluded that negotiations should commence immediately with Dalhousie University for the purpose of designating the Province's current contribution to residency programs to specific areas of need.

5. The Committee also recognized that with particular specialties, the number of residency positions are quite limited. The province of origin for the medical school is no longer prepared to pay for a residency position when the individual is not interested in staying in that Province after training. Therefore, P.E.I. must more aggressively pursue the purchase of residency positions to secure our physician needs. The Committee identified the need for the establishment of a policy for the purchase of residency positions which should immediately be implemented for the areas where greatest need has been identified, those being Otolaryngology, Lab Medicine and Psychiatry.

TABLE X
SUMMARY OF RECRUITMENT REQUIREMENTS

SPECIALTY	FT EQUIVAl.	RECOMMEND COMPLEMENT	REQ. RECRUITMENT SHORT TERM	LONG TERM
Family Practice	72	74	2	7
Anesthesia	7	8	1	2
General Surgery	6	7	1	1
Internal Medicine	9	10	1	2
Obs/Gyn	7	7	1	3
Ophthalmology	3	3	-	-
Orthopedic Surgery	3	3	-	-
Otolaryngology	3	3	1	1
Pediatrics	3	4	1	-
Psychiatry	7	*	*	*
Urology	2	2	-	-
Dermatology	1	1	-	-
Physical Medicine	1	1	-	-
Oncology	1	2	1	-
Pathology	4	7	3	2
Radiology	5	8	2	2
Plastics	2	2	-	-
Neurology	-	1	-	1
Medical Director(HHSC)	1	1	1	-
Public Health Officer	1	1	1	-
Emergency Room Phys.	-	1	1	-

* Recommended complement not defined

6. IMPLEMENTATION

6.1 Management Approaches

The Committee heard unanimous support for the need of a management approach for the identification, flow and distribution of physicians into Prince Edward Island. As to what that approach would be requires considerable attention. In the document "Present Dilemma in Medical Manpower: The National Perspective, Jan 1988", Mr. Orvill B. Adams of the Canadian Medical Association identified a number of methodologies which serve in human resource planning. They include:

a) The supply projection approach on physician/population ratios. It involves relating the total population being serviced to the total pool of practicing physicians, taking into account population growth and the attrition rate of physicians.

b) The service provision approach takes into account the productivity of the practicing physicians, the attrition rate among physicians, changes in the ratio of male and female physicians, changing work patterns and projected changes in health care delivery needs.

c) The health-and-sickness-needs approach requires predicting future incidence and prevalence of disease, the types of physicians who will provide the services, and how many such services can be reasonably expected by a provider in a specific period of time. This leads to a prediction of how many and what types of physicians will be required.

d) The marketplace approach allows for the demand for services to determine supply of physicians.

e) The how-many-can-be-afforded system sets physician numbers based on dollars available.

Mr. Adams suggests that while it must be adapted for specific factors, the service provision approach is more satisfactory than other methodologies. It is particularly more so than the marketplace approach, now in

place, which is not applicable to Canada's universal health insurance system, because the perception of "free" service distorts the marketplace.

The Committee concurred with this opinion and recognizes that the appropriate methodology must be developed for physician resource planning. It must be understood that this cannot be done in isolation of the total organization and the planning strategies being delivered for the rest of the health care system.

6.2 Implementation Approaches

The Committee reviewed the methods used by other provinces for the implementation of a physician resource plan. There is a range of alternatives Prince Edward Island can consider:

1) Persuasion,
2) Informal, in conjunction with the hospital and medical community,
3) Via hospital admitting privileges process,
4) Government control, or
5) Committee management structure.

It is expected that Prince Edward Island will experience increased pressure from more physicians wishing to enter the province as other parts of the country establish plans and implement control measures. The Committee cannot accept the absence of a specific method of management nor can it condone perceived or complete government control. It is important therefore to establish a structure which is flexible in nature and yet has a sound management ability.

The Committee concluded that a permanent management committee structure be established for the purposes of directing and managing a physician resource plan for the Province.

This Committee would be comprised of membership equally from the medical, hospital and government communities and would have responsibility for maintaining an annual resource plan.

The role of this proposed Physician Resource Planning Committee would be as follows:

- to maintain an annual physician resource plan based on the needs of the Island health care system,
- to determine a recruitment schedule for new physicians based on the priority of deficiencies in this plan,
- to determine eligibility for the provision of insured services based on the recruitment schedule,
- to develop, in conjunction with the health care community, a system for recruitment based on the principle of merit, and
- to coordinate the implementation of the resource plan with the College of Physicians and Surgeons.

The bonus of a committee structure is such that it will facilitate communication among all the parties, identify areas of research for the provision of health care, and develop alternate mechanisms of payment.

In its deliberations on possible alternative management approaches the Medical Personnel Committee felt the effectiveness of any process would fall short unless it had a legislative component. The fear of a legislative mandate has normally rested with the premise of a Government controlled mechanism. It must be emphasized that the proposed Committee would be independent of Government and not under the influence of Government direction.

The Medical Personnel Committee believes this proposed committee should be immediately struck to:

1. develop terms of reference for the establishment of a permanent management committee,
2. coordinate the smooth implementation of the physician resource plan,
3. establish an interim plan which may call upon hospitals to limit hospitals admitting privileges, and
4. establish the appropriate resource staff in the Hospital and Health Services Commission to commence development for an ongoing monitoring process.

While the implementation of the proposed management structure requires considerable effort, commitment and compromise on the part of all players, the Committee firmly believes that it will only be with this implementation that the Province can experience an effective mechanism for the provision of physician supply.

CONCLUSION

The Medical Personnel Advisory Committee is pleased to have initiated such a challenging and creative task. The Committee has been able to make a number of recommendations that we hope will be able to direct and improve the delivery of health services. The Committee cautions that, because the supply of physicians is represented at a particular point in time, the data is almost always out of date. The Committee is aware that adjustments could be made to the document to reflect changes to the defined complement.

As the task of the Committee evolved it was recognized there was a need to broaden the perspective. Although the issue of physician numbers is most important, other issues which influence physician supply and the supply of services are having a major effect on the efficiency and the effectiveness of health care delivery on Prince Edward Island.

What was most surprising to the Committee was the extent of the willingness of the health community to not only participate in this exercise but to recognize with almost total provincial consensus the need for a strong managed approach to the provision of physician services.

The Committee has seen this and many other positive benefits from the exercise. The greatest benefit is the opening of the communication lines among the many players. It is the hope of the Committee that this will continue to be a great asset as the process matures and as the health community is further challenged.

RECOMMENDATIONS

1. That the Hospital and Health Services Commission initiate a thorough review of the use of out-of-province services with the objective of establishing a formal and comprehensive approval process.

2. That the growth of out-patient clinics be more directed and there be no further development until there has been a complete evaluation.

3. That there be an assessment and evaluation of the current and future use of out-of-province clinics.

4. That work commence immediately with the Medical Society in an effort to identify how changes can be made to return the delivery of primary services to the family physician.

5. That the Commission investigate the opportunities for a research project identifying the potential unique patterns of practice offered by female physicians.

6. That innovative models be explored for the purpose of providing physicians with continuing education programs within their community setting.

7. That the Commission develop an awareness program to better inform Island residents on the use and cost of the health system.

8. That leadership qualities in Family Physicians be challenged so that better services and the integration of related health service professionals can be achieved.

9. That, in the provision of provincial services, Prince County Hospital be made responsible for the appropriate delivery of radiology services for the three western hospitals and Queen Elizabeth Hospital be responsible for ensuring service to the two eastern hospitals.

10. That the following hospitals expand their complement of physicians:

    - Western Hospital expand Family Physician complement by one, (already accomplished)

    - Community Hospital expand Family Physician complement by one,

- Prince County Hospital immediately expand its complement to include an internist (accomplished), a psychiatrist, a pathologist, a radiologist and a general surgeon, and

- Queen Elizabeth Hospital immediately expand its complement to include two pathologists, a radiologist, a psychiatrist an anesthesist, a pediatrician, an oncologist and an emergency room physician.

11. That the College of Physicians and Surgeons of Prince Edward Island comply with the criteria being developed by a National Task Force of the Canadian Medical Association on the training requirements for family physicians providing anesthestic services and Community Hospital not attract a family physician with specialty in anesthesia until the Canadian Medical Association Task Force has completed its work.

12. That mechanisms be immediately explored which would assist Stewart Memorial Hospital in their requirements for on-call services.

13. That during the development of the hospital delivery plan, consideration be given to identifying where core specialty services would be available and where other specialties would be established as a center of excellence.

14. That the Medical Director of the Hospital and Health Services Commission work with the Prince County Hospital in developing options to the provision of pediatric coverage.

15. That aggressive recruitment commence in Otolaryngology (ENT), psychiatry, lab medicine, obstetrics and pediatrics. Further recruitment be considered within the next five years for general surgeon, emergency room physician, oncologist, anesthetists, radiologists and family physicians in those hospitals where need has been accepted.

16. That the physician resource plan be circulated and discussed with all Island students presently in medical school and that the Medical Society and the Hospital and Health Services Commission annually discuss future opportunities with students entering the medical program and encourage that they focus their training in areas of need.

17. That negotiations commence immediately with Dalhousie University for the purpose of designating the Province's current contribution to residency program to specific areas of need.

18. That a policy for the purchase of residency positions be established and immediately implemented for the areas where greatest need has been identified, those being Otolaryngology, Lab Medicine and Psychiatry.

19. That a permanent committee structure be established for the purpose of managing a physician resource plan.

APPENDIX I

PRESENTATIONS TO MEDICAL PERSONNEL COMMITTEE

Community Hospital	-	O'Leary
Kings County Memorial Hospital	-	Montague
Prince County Hospital	-	Summerside
Queen Elizabeth Hospital	-	Charlottetown
Souris Hospital	-	Souris
Stewart Memorial Hospital	-	Tyne Valley
Western Hospital	-	Alberton

P.E.I. Medical Society

P.E.I. College of Family Physicians

Department of Health and Social Services

APPENDIX II

SUBMISSIONS TO MEDICAL PERSONNEL COMMITTEE

South Shore Medical & Community Services

Community of Sherwood

P.E.I. Association for Community Living

P.E.I. Council of the Disabled Inc.

Women's Network

P.E.I. Division, Canadian Cancer Society

Allergy & Environmental Illness Group

Epilepsy P.E.I. Inc.

P.E.I. Advisory Council on the Status of Women

The P.E.I. Psychiatric Association

Dr. John Craig

Mrs. R. A. Pinkham

Mrs. Elizabeth Fitzgerald

CLINICS
Queen Elizabeth Hospital

APPENDIX III

TYPE OF CLINIC	NAME OF CLINIC	LOCATION	DURATION	DOCTOR/STAFF	PURPOSE
OUT-OF-PROVINCE PHYSICIAN CLINICS	Pediatric Neurologist	Physical Medicine	3-4 days/ q 2-3 months	Dr. Tibbles(N.S.)	Referrals from P.E.I. physicians for specialist services not available here.
	Developmental Specialist	Physical Medicine	1 1/2 -2 days/ yearly	Dr. Keet (N.S.)	Referrals from P.E.I. physicians for specialist services not available here.
	Genetic Counselling	Physical Medicine	1 1/2 -2 days/ q 6 months	Dr. Welch (N.S.)	Referrals from P.E.I. physicians for specialist services not available here.
	Pediatric Orthopedic	Physical Medicine	2 days/ q 2-3 months	Dr. Hyndman (N.S.)	Specializes in Pediatric Orthopedics as opposed to General Orthopedics.
	Neuro-Surgery	Physical Medicine	1 day/q 6-8 weeks	Dr. Howes, Dr. Huestis Dr. Holness (N.S.)	Review patients referred for neurosurgical conditions.
	E.M.G.	Physical Medicine	2 days/month	Dr. Patil (N.S.)	Electomyography-patients referred for nerve studies.
	Cystic Fibrosis	Special Services	2 days/ q 4 months	Dr. Gillespie (N.S.)	Mainly Cystic Fibrosis but some asthmatic patients as well.
	Respiratory	Special Services	4-5 days/q 6 mths	Dr. Gillespie (N.S.)	Respiratory problems only.
	Metabolic	Special Services	1 day/1-2 times/yr	Dr. Cole (N.S.)	Sees referrals from Island physicians. Many prior tests required for evaluation by specialists.
	Pediatric Cardiology	Special Services	2 to 2 1/2 days/ 3-4 times/year	Dr. Roy, Dr. Nanton Dr. Finley (N.S.)	Assessment and continued review for possible pre and post surgery patients.
	Peri-Natal follow-up	Special Services	1 every 6 months	Grace Maternity Hospital Staff Dr. Nwaesei	Grace Maternity team visit and assess all babies born at Grace Maternity up to the age of two yrs.

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